



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

FRISCO MEDICAL CENTER

**Respondent Name**

AMERICAN ZURICH INSURANCE COMPANY

**MFDR Tracking Number**

M4-18-0562-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

October 30, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please note per the NCCI Edits this line is not bundled and with a status indicator of 'S' this should have processed for payment."

**Amount in Dispute:** \$446.24

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "It denied additional reimbursement because the benefits for the services denied were included in the payment/allowance for the services which had been paid."

**Response Submitted by:** Flahive, Odgen & Latson, Attorneys At Law, PC

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 8, 2017	Outpatient Hospital Services	\$446.24	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
  - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

- 4915 – THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPTS SCHEDULE ALLOWANCE

### Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at <http://www.cms.gov>.

Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at [www.cms.gov](http://www.cms.gov).

The requestor asserts that, "per the NCCI Edits this line is not bundled."

Please note that code 76000 (below) is not bundled due to any NCCI edit, but rather is packaged due to OPPS payment policies regarding comprehensive payment codes with status indicator J1. Please refer to *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, **Part B Hospital** (Including Inpatient Hospital Part B and OPPS), §10.2.3 regarding Comprehensive APCs for further information on this payment policy.

Reimbursement for the disputed services is calculated as follows:

- Per Medicare payment policy, procedure code 76000 is packaged with J1 status code, 26951, billed on the same claim. Reimbursement for this service is included with payment for the primary comprehensive procedure. Separate payment is not recommended.  
The requestor asserts that, "per the NCCI Edits this line is not bundled." Please note that code 76000 is not bundled due to an NCCI edit, but rather the OPPS payment policies regarding comprehensive payment codes with status indicator J1. Please refer to *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, **Part B Hospital** (Including Inpatient Hospital Part B and OPPS), §10.2.3 regarding Comprehensive APCs for further information on this payment policy.
  - Procedure code 73140 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with J1 status code, 26951, billed on the same claim. Reimbursement for this service is included with payment for the primary comprehensive procedure. Separate payment is not recommended.
  - Procedure code 26951 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive service, ambulance and mammography). This is assigned APC 5113. The OPPS Addendum A rate is \$2,438.34. This is multiplied by 60% for an unadjusted labor-related amount of \$1,463.00, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of \$1,432.86. The non-labor related portion is 40% of the APC rate, or \$975.34. The sum of the labor and non-labor portions is \$2,408.20. The cost of services does not exceed the fixed-dollar threshold of \$3,825. The outlier payment is \$0. The Medicare facility specific amount of \$2,408.20, is multiplied by 200% for a MAR of \$4,816.40.
2. The total recommended reimbursement for the disputed services is \$4,816.40. The insurance carrier has paid \$4,816.40 leaving an amount due to the requestor of \$0.00. Additional payment is not recommended.

## **Conclusion**

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

## **Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>December 8, 2017</u>
Signature	Medical Fee Dispute Resolution Officer	Date

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.